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On December 23, 1974, in an opinion written by Justice Tobriner, the California Supreme Court in *Tarasoff v. Regents of the University of California* held that "a doctor or a psychotherapist treating a mentally ill patient . . . bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment."[1] Reaction to the holding was swift, and, especially from the psychiatric community, generally negative.[2] Probably because of the reaction, the court granted a rehearing. A year and one half later, the court handed down a second opinion that changed the emphasis of the initial holding in subtle but potentially significant ways.[3]

Critics perceived *Tarasoff* as a dangerous and unwarranted extension of liability. Dire warnings of the destruction of the therapeutic relationship, of the concomitant increase in crime, of the straight jacketing of the psychiatric profession, and of massive increases in involuntary commitments typified the emotional response which the case engendered.[4] Although not all commentators have been as unfavorable,[5] the resounding criticism of the case tended to obscure the meaning and application of the holding.

The ultimate holding of the second opinion, its place in the broad spectrum of duty and liability, and its meaning to the practicing psychotherapist[6] are the subject of this Note. It will be suggested

1. 529 P.2d 553, 559, 118 Cal. Rptr. 129, 135 (1974).

2. *See, e.g.*, TIME, Jan. 20, 1975, at 56.

3. Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

4. *See, e.g., id.* at 452, 551 P.2d at 354, 131 Cal. Rptr. at 35 (Clark, J., dissenting, 1976); Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976); Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025, 1045 (1974) [hereinafter cited as Fleming & Maximov]; 28 VAND. L. REV. 631, 638-39 (1975); TIME, Jan. 20, 1975, at 56. *See also*, Note, *Medical Malpractice, The Liability of Psychiatrists*, 48 NOTRE DAME LAW 693 (1973).

5. *See, e.g.*, Ayres & Holbrook, *Law, Psychotherapy, and the Duty to Warn: A Tragic Trilogy?*, 27 BAYLOR L. REV. 677 (1975) [hereinafter cited as Ayres & Holbrook]; Comment, *Tarasoff and the Psychotherapist's Duty to Warn*, 12 SAN DIEGO L. REV. 32 (1975); Note, *Tarasoff v. Regents of the University of California*, 6 GOLDEN GATE L. REV. 229 (1975); 44 CIN. L. REV. 368 (1975).

6. Psychotherapy is defined as "a verbal relationship between a professional and

that the *Tarasoff* decision, although startling to psychotherapists, is within the mainstream of California duty principles. In addition, it is suggested that the scope of the *Tarasoff* duty should be limited by the further refinement of an applicable standard of care.

This Note is divided into four sections. The first section examines the genesis of the case and highlights the differences between the first and second opinions. The second section probes the legal and policy foundations of the case and attempts to place the holding in context within the mainstream of California concepts of duty. The third section examines the principal objections to the holding: that it will destroy the confidentiality necessary to psychotherapy and that it will lead either to overcommitment or an impractical standard of care because of psychotherapists' inability to predict violence. The final section explores various strategies in an attempt to define an applicable standard of care. A standard is proposed that retains the policy goals of the *Tarasoff* holding while answering some of the objections to the case.

Genesis

Factual Context

In August 1969, Prosenjit Poddar was a voluntary outpatient receiving therapy at the University of California's Cowell Memorial Hospital. He told his therapist, Dr. Moore, of his plan to kill an unnamed, but readily identifiable girl when she returned home from summer vacation. Dr. Moore, with the concurrence of two other psychiatrists, decided to commit Poddar to a mental hospital for observation. Dr. Moore orally notified campus police and later sent a letter requesting their assistance in detaining Poddar. The police took Poddar into custody but soon released him after he promised to stay away from his intended victim. The director of the department of psychiatry at Cowell then asked the police to return Dr. Moore's letter and directed that all copies of the letter, as well as Dr. Moore's notes, be destroyed.[7] No subsequent attempt was made to commit Poddar, who had broken all connections with the hospital and had

a client focused on the thoughts, feelings, and behavior of the troubled person . . . . The aim of this exchange is to help the client understand the nature of his problems and assist him in designing a rewarding and less painful way of life." PSYCHOLOGY TODAY, AN INTRODUCTION (1970) at 518. *See also* CAL. BUS. & PROF. CODE § 2903 (West 1974). Psychotherapist is defined to include a psychiatrist (a medical doctor devoting a substantial amount of his time to the practice of psychiatry), a licensed psychologist, a licensed clinical social worker, a credentialed school psychologist, and a licensed marriage, family, or child counselor; CAL. EVID. CODE § 1010 (West, Supp. 1977).

7. 529 P.2d 553, 556, 118 Cal. Rptr. 129, 132 (1974).

ended therapy after the incident with the campus police.[8] On October 27, 1969, Poddar killed Tatiana Tarasoff, his intended victim.[9]

Tatiana's parents brought suits against the psychiatrists, the police officers, and the University of California, alleging a failure to warn plaintiffs of the impending danger and failure to use reasonable care to bring about Poddar's confinement pursuant to California's involuntary commitment statute, the Lanterman-Petris-Short Act.[10] The superior court sustained the defendants' demurrers without leave to amend, and an appeal ensued.

The First Opinion — Tarasoff I

The issue presented to the court became a narrow one. Because governmental immunity protected a psychotherapist working for the state from liability for failure to commit a patient,[11] the only clear basis for liability seemed to be the so-called "duty to warn."[12] The court found two independent bases for imposing a duty to warn threatened persons of danger arising from the condition of a psychotherapist's patient: the special relationship between the psychiatrists and Poddar and the defendants' "bungled attempt" to confine Poddar.[13] The court noted that at common law there was generally no duty to control the conduct of another or to warn a third person of another's dangerous proclivities. Exceptions to this rule were found if there was a special relationship between the defendant and either the person whose conduct needed to be controlled or the foreseeable victim, and if a defendant had undertaken some affirmative action to protect the intended victim.[14]

In examining the special relationship exception, the court noted that applicable California decisions involved factual situations in which the defendant stood in a special relationship with *both* the victim and the person whose conduct created the danger. The court found no reason to constrict a duty to warn to such situations and cited decisions from other jurisdictions finding doctors liable to third persons

8. 529 P.2d at 559, 118 Cal. Rptr. at 135.

9. 529 P.2d at 554, 118 Cal. Rptr. at 130. The criminal case is reported in People v. Poddar, 10 Cal. 3d 750, 518 P.2d 342, 111 Cal. Rptr. 910 (1974).

10. CAL. WELF. & INST. CODE §§ 5000-5404.1 (West 1972 & Supp. 1977). See notes 60-63 *infra*.

11. Section 856 of the Government Code affords public entities and their employees absolute protection from liability for "any injury resulting from determining in accordance with any applicable enactment . . . [w]hether to confine a person for mental illness." CAL. GOV'T. CODE § 856 (West 1969 & Supp. 1970).

12. Tarasoff v. Regents of the Univ. of Cal., 529 P.2d 553, 563, 118 Cal. Rptr. 129, 139 (1974). *See also* Ayres & Holbrook, *supra* note 5, at 680.

13. 529 P.2d at 555, 118 Cal. Rptr. at 131.

14. 529 P.2d at 557, 118 Cal. Rptr at 133. See note 41 *infra*.

for negligently failing to diagnose contagious diseases.[15] The court reasoned that a mentally disturbed patient's dangerous proclivities could be as serious and foreseeable as those of a carrier of contagious disease.[16]

The defendants had primarily argued that policy considerations should preclude liability. First, they had argued that the difficulties in predicting violence made imposition of a duty to warn unworkable and disruptive of the therapeutic relationship. Although recognizing these difficulties, the court found them to be no more insurmountable than the diagnostic problems faced by a medical doctor. Weighed against those difficulties, the public's interest in safety was paramount.[17] Second, the defendants had argued that free and open communication is essential to psychotherapy and that a duty to warn would destroy the trust and confidentiality that lies at the foundation of therapy. Treatment would be undermined, and potential patients would be deterred from seeking therapy. Although recognizing the public interest in effective treatment, the court nevertheless rejected the contention. It found that the "difficult task of balancing the countervailing concerns"[18] had already been undertaken by the legislature in section 1024 of the Evidence Code.[19]

Justice Clark vigorously dissented. He argued that policy considerations would not support the imposition of the duty. He contended that the absolute necessity of confidentiality in psychotherapy should preclude liability.[20] He cautioned that if confidentiality were undermined, some patients would be deterred from seeking psychotherapy while patients who were not deterred would be unable to respond to therapy with the spontaneous, open communication required for effective treatment. Justice Clark believed the *Tarasoff* duty would cripple the effectiveness of psychotherapy. Therefore, in his opinion, the net effect of the holding would be to contribute to an increase in violence.[21] The legislature in enacting section 1024 of the Evidence Code authorizing disclosure where a patient presents a dan-

15. 529 P.2d at 559, 118 Cal. Rptr. at 135.

16. *Id.* With little discussion, the court also found that the police officers could be held liable for failure to warn on the theory that their conduct increased the risk of violence. 529 P.2d at 561, 118 Cal. Rptr. at 137.

17. 529 P.2d at 560, 118 Cal. Rptr. at 136.

18. *Id.*

19. "There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." CAL. EVID. CODE § 1024 (West 1966).

20. 529 P.2d at 566-67, 118 Cal. Rptr. at 142-43 (Clark, J., dissenting).

21. 529 P.2d at 567-68, 118 Cal. Rptr. at 143-44.

ger to himself or others had never intended to require an affirmative duty to disclose.[22]

The Second Opinion — Tarasoff II

After rehearing the case, the court handed down an opinion which is replete with significant differences from the first opinion.[23] The court retreated from its imposition of an absolute duty to warn. Instead, it employed a two level analysis to determine whether the psychotherapist met the requisite standard of care. First, the standards of the profession are utilized to determine whether a psychotherapist using reasonable care would have foreseen that the patient presented a serious danger of violence to another. If so, the psychotherapist incurs a duty to protect the threatened victim. Second, the discharge of this duty is assessed. The traditional negligence standard is utilized to determine whether the psychotherapist used reasonable care to protect the threatened victim.[24] The court recognizes that psychotherapists have alternative means of discharging this duty of reasonable care, including warning the victim or the police, securing voluntary or involuntary commitment, or taking "whatever other steps are reasonably necessary under the circumstances."[25]

The court emphasized the narrowness of its holding. It underlined the fact that the psychiatrists' attempt to confine Poddar was an admission of his dangerousness, thereby removing any issue of foreseeability from the case.[26] The holding was limited to psychotherapists.[27]

Because foreseeability was not in issue, the precise standard of care[28] required of a psychotherapist was left unclear, but the court indicated that the standard would take into account the special circumstances of psychotherapy. Recognizing the difficulty in predicting

22. 529 P.2d at 568-69, 118 Cal. Rptr. at 145-46.

23. Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

24. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

25. *Id.* With scant discussion, the court dismissed the complaint against the police officers because they lacked the requisite special relationship with Poddar or the victim upon which a duty could be imposed. *Id.* at 444, 551 P.2d at 349, 131 Cal. Rptr. at 29.

26. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

27. *Id.* at 437, 551 P.2d at 345, 131 Cal. Rptr. at 20. The first opinion applied the duty to doctors. Tarasoff v. Regents of the Univ. of Cal., 529 P.2d 553, 118 Cal. Rptr. 129, 135 (1974).

28. The court held that a psychotherapist would be held to a professional standard of care in attempting to "forecast whether a patient presents a serious danger of violence." *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25. It left unclear what conduct by a patient would raise the duty to act. Because foreseeability was not in issue in *Tarasoff*, the court did not indicate under what circumstances the duty would be raised.

violence, the court did not require a perfect performance, rather, only the exercise of that "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by [psychotherapists] under similar circumstances."[29] Within the broad range in which "professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight . . . is insufficient to establish negligence."[30] Further, the court added an important caveat that no routine disclosures will be required. In fact, even if a warning should become necessary, the psychotherapist should make it in a fashion that is discrete and that will "preserve the privacy of the patient to the fullest extent compatible with the prevention of the threatened danger."[31] Although much remains to be formulated in later decisions, the court indicated that an applicable standard of care would be narrow.[32] Thus the *Tarasoff II* opinion is tailored to better reflect the realities of psychotherapy.[33]

Other differences between the two opinions can be traced to new arguments by the defendants and the dissent in *Tarasoff II*. The court rejected Justice Clark's contention[34] that the Lanterman-Petris-Short Act's sections on confidentiality[35] barred a warning. The court held that the provisions of the Act did not apply and that they should not be imported "wholesale" into all therapeutic relationships.[36] The court likewise rejected the argument that the duty would be unworkable and would lead to overcommitment because of the inability of therapists to predict violence.[37]

29. *Id.*, (quoting Bardessono v. Michels, 3 Cal. 3d 780, 788, 478 P.2d 480, 484, 91 Cal. Rptr. 760, 764 (1970)).

30. 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

31. *Id.* at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

32. *Id.*

33. In adopting this less constricted formulation of duty, the court dropped the "bungled attempt to confine" basis of liability relied upon in the first opinion.

34. *Id.* at 453-57, 551 P.2d at 355-58, 131 Cal. Rptr. at 35-38 (Clark, J., dissenting).

35. CAL. WELF. & INST. CODE §§ 5328-5330 (West 1972 & Supp. 1976). Section 5328 provides that "[a]ll information and records obtained in the course of providing services . . . to either voluntary or involuntary recipients of services shall be confidential." Section 5330 provides damages and injunctive relief for violations. Limited exceptions to the rule are found in §§ 5328, 5328.2, mainly relating to reports to police and judicial authorities. For a discussion of the Act's applicability, see notes 60-63 & accompanying text *infra*.

36. 17 Cal. 3d at 442-43, 551 P.2d at 348-49, 118 Cal. Rptr. at 28-29. The court reasoned that the act did not apply for two reasons. First, the psychiatrists were not designated pursuant to the act to initiate involuntary commitment procedures and, second, the confidentiality sections apply only in the course of providing services under the act, which was not done with Poddar. *Id.* at 442-43, 551 P.2d at 348, 131 Cal. Rptr. at 28.

37. *Id.* at 437-39, 551 P.2d at 344-45, 131 Cal. Rptr. at 24-25.

Justice Mosk broke with the majority in the second opinion, concurring in part and dissenting in part. He concurred with the result only because the defendants did in fact, predict that Poddar was dangerous. He believed that the issue should thus be decided narrowly.[38] He dissented from the majority's broad duty of care because of a lack of standards for predicting a patient's tendency towards violence. Arguing that psychiatric predictions are inherently unreliable, he urged restructuring the rule to impose liability only in cases in which a psychiatrist does in fact predict violence.[39]

Thus the issues and the lines of battle are relatively distinctly drawn. The *Tarasoff II* opinion requires a re-examination of both the policy bases and the objections to the original holding. This Note will consider the court's rationale and further elaboration of the standard of care and attempt to formulate and predict the ultimate contours of the psychotherapist's new duty.

The Legal and Policy Basis for the Psychotherapist's Duty

Common Law

As a general rule at common law, there was no duty to control the conduct of another or to warn those endangered.[40] Exceptions were carved out of this harsh concept when there was some sort of special relationship with the person whose conduct posed the danger or with the person who was threatened.[41] In California, courts found a duty of parents to warn a babysitter of the violent propensities of their child,[42] as well as a duty of the state to warn foster parents of the dangerous tendencies of their ward.[43] In these cases the duty was based on the special relationships with the person whose conduct posed the danger and with the person threatened. The right of custody or control that a parent or a state retains over its ward or special knowledge of dangerous tendencies established the special relationship. As developed, the duty does not require a relationship with both the actor and the person threatened in order to impose liability.[44]

38. *Id.* at 451, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34 (Mosk, J., concurring and dissenting).

39. *Id.* at 451-52, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34.

40. *See, e.g.*, Richards v. Stanley, 43 Cal. 2d 60, 65, 271 P.2d 23, 27 (1954).

41. *See, e.g.*, RESTATEMENT SECOND OF TORTS, §§ 315-320 (1965).

42. Ellis v. D'Angelo, 116 Cal. App. 2d 310, 253 P.2d 675 (1953).

43. Johnson v. State, 69 Cal. 2d 782, 447 P.2d 352, 73 Cal. Rptr. 240 (1968).

44. *See, e.g.*, Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 436, 551 P.2d 334, 344, 131 Cal. Rptr. 14, 24 (1976).

Special Relationships Based on the Right of Custody and Control

One classic formulation of the special relationship exception arises in circumstances in which one has the right or power to impose custody and control over a third party. Liability for the damage to another may be predicated upon failure to exercise that power.

The relationship that a hospital or a mental institution has with its patient has been found to support such a duty. Thus a hospital may be found liable for wrongful death if it had knowledge from which it might have reasonably concluded that a patient was likely to harm himself or others and it subsequently failed to take steps to avert such harm.[45]

The duty is based on a right or power to impose custody or control, rather than actual custody. Thus, in so-called "negligent release" cases, liability has been found for the acts of a patient after release from the institution.[46] A mental hospital that prematurely released a patient who was still mentally disturbed was found liable for his damaging acts.[47]

The rule of liability has been extended to cases in which there was only a potential power or right of custody. In *Greenberg v. Barbour*,[48] a hospital negligently failed to admit a man whose dangerous tendencies were known to the staff. The would-be patient left and assaulted a third person who later sued the hospital. In reversing a summary judgment for the defendant hospital, the appellate court acknowledged that liability could be imposed on the hospital.[49]

The "custody and control" concept is akin to the common law doctrine of misfeasance.[50] The hospital or doctor in entering into an active relationship with a patient assumes an affirmative duty to exercise reasonable care to protect the patient and third parties. Thus, the mere potential power to exercise custody or control over the patient would seem to be a sufficient basis on which to impose liability if a special relationship exists with either the dangerous actor or the

45. Vistica v. Presbyterian Hosp., 67 Cal. 2d 465, 469, 432 P.2d 193, 62 Cal. Rptr. 577 (1967). A hospital was found liable for failure to take precautions to prevent a patient from committing suicide in Meier v. Ross Gen. Hosp., 69 Cal. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968).

46. *See, e.g.*, Underwood v. United States, 356 F.2d 92 (5th Cir. 1966); Fair v. United States, 234 F.2d 288 (5th Cir. 1956).

47. *See, e.g.*, Homere v. State, 79 Misc.2d 972, 361 N.Y.S.2d 820 (1974); Austin W. Jones Co. v. State, 122 Me. 214, 119 A. 577 (1923). *See also* Merchants Nat'l Bank & Trust Co. v. United States, 272 F. Supp. 409 (D.N.D. 1967).

48. 322 F. Supp. 745 (E.D. Pa. 1971).

49. *Id.* at 747.

50. *See, e.g.*, Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 435 n.5, 551 P.2d 334, 343, 131 Cal. Rptr. 14, 23 (1976); Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886, 887 (1934).

person threatened. This concept legitimately can be applied to a psychotherapist.

The psychotherapist stands in a unique position in society. He exercises a social control function and acts as a safety valve for a society that looks to him to control and cure the threatening problems of mental disease.[51] More than any other professional, the psychotherapist is expected to tell society who is dangerous and what must be done about it.[52] The courts increasingly rely upon psychotherapists in a variety of contexts in both criminal and civil proceedings.[53]

To his patient, the psychotherapist occupies a unique position that coalesces the power and authority of a doctor, a confessor, and a hospital. He potentially exercises powers of control and custody sufficiently analagous to a hospital or a parent to support a duty to act.

Psychotherapy is a relationship of trust. The psychotherapist acquires a considerable degree of influence over a patient and can often convince a seriously disturbed and potentially dangerous patient voluntarily to commit himself or to embark on intensive treatment.[54] This influence is especially apparent with the class of patients who come to their therapists with a cry for help, pleading for someone to control their dangerous proclivities.[55]

The greatest control a therapist can exercise is to recommend commitment. In the judicial setting, he acts as more than a mere advisor to the court. Functioning like an arm of the court, he is virtually an unimpeachable witness.[56]

Most civil commitment statutes provide for special procedures to commit dangerously disturbed patients. These statutes generally require a psychiatric determination of dangerousness, which is usually

51. *See, e.g.*, L. TANCREDI, J. LIEB & A. SLABY, LEGAL ISSUES IN PSYCHIATRIC CARE 18 (1975). *See generally*, D. MECHANIC, MENTAL HEALTH AND SOCIAL POLICY (1969) [hereinafter cited as Mechanic].

52. Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288, 1290 (1966).

53. *See, e.g.*, Note, *Donaldson, Dangerousness, and the Right to Treatment*, 3 HASTINGS CONST. L.Q. 599, 622 (1976); Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 440 (1974). If the American Law Institute has its way, this trend will continue. *See, e.g.*, MODEL PENAL CODE § 7.03 (proposed official draft, May, 1962).

54. L. TANCREDI, J. LIEB & A. SLABY, LEGAL ISSUES IN PSYCHIATRIC CARE 140 (1975).

55. *Id.* "[W]hen a patient discusses a desire to take his own life or another's life, it is clear that he is telling his therapist because he wants to be controlled and protected from himself. It is usually, therefore, possible for a skilled therapist to persuade a violent patient to submit voluntarily to hospitalization . . . ." *Id.*

56. *See, e.g.*, Fleming & Maximov, *supra* note 4, at 1036-37; Note, *Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act*, 7 LOY. L.A. L. REV. 93, 125 (1974).

made by the patient's psychiatrist or by a court appointed psychiatrist.[57] On the basis of these diagnoses, fifty thousand people in the United States are committed each year.[58]

In California, a comprehensive mental health program was established by the Lanterman-Petris-Short Act,[59] which was in effect at the time the events in *Tarasoff* took place. The Act regulates involuntary commitment procedures for dangerous patients. Although providing more safeguards for the patient than most statutory schemes found in other states,[60] it authorizes designated psychotherapists to place persons they believe to be dangerous in confinement for an initial seventy-two hours.[61] This period may be extended in cases in which the patient is believed to remain dangerous.[62] The Act has not created a blanket, arbitrary power but has conferred upon a psychotherapist grave responsibilities. A psychotherapist acting pursuant to the Act is cloaked with immunity from liability.[63]

The psychotherapist's potential to control a patient requires a duty of responsible execution. Generally, courts have found psycho-

57. *See, e.g.*, Kozel, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELIN. 371, 374 (1972).

58. Rubin, *The Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIAT. 397 (1972).

59. CAL. WELF. & INST. CODE §§ 5000-5404.1 (West 1972 & Supp. 1977).

60. CAL. WELF. & INST. CODE §§ 5252.1-5255, 5301-5302, 5328 (West 1972) provides *Miranda*-like notification of the right to have an attorney, to seek habeas corpus relief, and to notify anyone of the certification for commitment and make a person liable for making false reports of dangerousness. Cal. Welf. & Inst. Code § 5325 (West 1972) lists patient rights while confined.

61. If a peace officer, member of the attending staff of a designated evaluation facility, or a professional designated by the county has probable cause to believe a person to be a danger to himself or others as a result of mental disorder, the officer may take or cause to be taken into custody that person for a period not to exceed 72 hours in a designated facility where evaluation and treatment are provided. CAL. WELF. & INST. CODE § 5150 (West Supp. 1977).

62. If a person committed under § 5150 is found to be dangerous or gravely disabled and has refused voluntary treatment, he may be certified for 14 days of intensive treatment. CAL. WELF. & INST. CODE § 5250 (West 1972). He may be certified, through a court order, for an additional 90 days if he has threatened, attempted, or inflicted physical harm and presents an imminent threat of substantial physical harm. CAL. WELF. & INST. CODE §§ 5300-5301 (West 1972). This period is renewable if the same conditions are met. CAL. WELF. & INST. CODE § 5304 (West 1972).

63. Authorized professionals, peace officers, and facilities are immune from liability for acts of the patient after release, CAL. WELF. & INST. CODE §§ 5113, 5154 (West 1972), and for exercising authority pursuant to the act. CAL. WELF. & INST. CODE § 5278 (West 1972). Further, public entities and their employees enjoy immunity from liability in determining whether to confine a person for mental illness. CAL. GOV'T. CODE § 856 (West Supp. 1970). *See* note 11 & accompanying text *supra*. There is liability, of course, for negligence of a private professional. The act provides for civil liability for knowing false statements that lead to commitment. CAL.

therapists liable when they have abused commitment powers.[64] As an extension of the common law custody and control concept, it is consistent and reasonable to impose liability upon a psychotherapist who fails to exercise these powers of control or otherwise use reasonable care to protect the potential victim from his dangerous patient.

Special Relationship Based on Professional Knowledge

A special relationship based upon professional knowledge or skills has been found to be a sufficient basis on which to predicate liability.[65] The imposition of duties based upon a doctor's professional knowledge is illustrative.

The burdens of professionalism are manifold.[66] A large number of statutory duties are based on a doctor's special knowledge. Reporting statutes commonly require a doctor to report to the authorities cases of contagious disease, gunshot wounds, and child battering.[67] A doctor's special skill in diagnosing these problems and his sometimes exclusive knowledge of his patients' problems make him, in many instances, society's last line of defense.

The doctor's duty is most apparent when he is faced with a patient carrying a contagious disease. He may be found liable to third persons who become infected because of his failure to diagnose[68] or to take proper precautions, which can include warning those endangered by the disease.[69]

WELF. & INST. CODE § 5150 (West Supp. 1976). For remedies for wilful detention beyond the 14 day certification period, *see* CAL. WELF. & INST. CODE § 5255 (West 1972), and for remedies for breach of confidentiality, *see* CAL. WELF. & INST. CODE § 5330 (West 1972).

64. Before the Lanterman-Petris-Short Act, liability for improper commitment was found on false imprisonment grounds. Maben v. Rankin, 55 Cal. 2d 139, 358 P.2d 681, 10 Cal. Rptr. 353 (1961). *See generally* 99 A.L.R.2d 599, 617-19 (1965). Such liability is presumably still applicable to private professionals. Under the Lanterman-Petris-Short Act, a designated psychotherapist is cloaked with immunity for all acts connected with commitment. See note 63 *supra*.

65. Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886, 897 (1934).

66. *See, e.g.*, 61 AM. JUR.2d, *Physicians and Surgeons and Other Healers* § 99.

67. *See, e.g.*, Note, *Psychiatrist-Patient Privilege — A Need for the Retention of the Future Crime Exception*, 52 IOWA L. REV. 1170, 1183 (1967). Many of these duties require circumvention of the doctor-patient privilege against the patient's wishes. *See, e.g.*, Note, *Protecting the Privacy of the Absent Patient, Rudrick v. Superior Court*, 27 HASTINGS L.J. 99, 131-32 (1975). Recently, noncompliance with a statute requiring reports of child-battering was made the basis of a doctor's liability for subsequent batterings. Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976).

68. *See, e.g.*, Hofmann v. Blackmon, 241 S.2d 752 (Fla. App., 1970).

69. *See, e.g.*, Jones v. Stanko, 118 Ohio St. 147, 160 N.E. 456 (1928); Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921); Skillings v. Allen, 143 Minn. 323, 173

Ethically, the doctor has duties to both society and his patient.[70] He can no more abandon his patient than he can ignore a potential risk to society.

The psychotherapist stands in much the same relationship to his patient and society as does a doctor. His skill and knowledge of psychiatry as well as of a particular patient's proclivities place him in an analogous position to a doctor.[71] Society, too, relies upon him to warn and protect it from danger.[72]

Because of his special relationship with a patient, a psychotherapist is likely to be the only one with knowledge of a potentially threatening situation. Often a patient reveals things to him that he tells no one else.[73] A patient may threaten future violent action because he wants to be controlled and protected from himself. The psychotherapist may then be able to persuade the patient to submit to voluntary hospitalization, he may initiate involuntary commitment proceedings, or he may warn threatened persons or the authorities.[74] The only real difference between the position of the doctor and the psychotherapist lies in the diagnostic ability to foresee dangerous behavior. The further development of a special standard of care for psychotherapists can go far towards minimizing this difference.

Modern Concepts of Duty

The psychotherapist's position of trust and authority, his potential power to initiate commitment proceedings, and his special knowledge of his patient are sufficient to establish the requisite special relationship required to impose a duty. Thus there appears to be ample precedent in the common law to establish a duty to control the conduct of a dangerous patient or to warn those persons threatened.[75] Prior to *Tarasoff*, no case had suggested such a duty, but the powers and responsibilities a psychotherapist possesses place the establishment of such a duty within the mainstream of modern concepts of duty.

The traditional approach to establishing a duty was to look to

N.W. 663 (1919); *see also* Wojcik v. Aluminum Co. of America, 18 Misc.2d 740, 183 N.Y.S.2d 351 (1959).

70. "The doctor's duty to the sick . . . includes a duty to keep others from getting sick." Sidel, *Confidential Information and the Physician*, 264 NEW ENGL. J. OF MED. 1133, 1135 (1961).

71. Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 438, 551 P.2d 334, 345, 131 Cal. Rptr. 14, 25 (1976).

72. See notes 51-56 & accompanying text *supra*.

73. *See, e.g.*, Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 185 (1960).

74. See notes 54-55 & accompanying text *supra*.

75. *See* Fleming & Maximov, *supra* note 4 at 1030; Ayres & Holbrook, *supra* note 5 at 680-684.

the common law for analogies. The modern approach looks beyond the common law to the social and economic relationships of the parties.[76] As Prosser stated, "'[D]uty' is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection."[77]

The last twenty years have seen California courts move from a rigid common law approach to duty to an expanded concept based upon an explicit recognition of the requirements of social policy.[78] This expansion of duty parallels an expanded view of the ethical responsibilities of the medical and psychiatric professions. From a narrow view of the two person, professional-patient relationship, professional ethics have been extended to include an ethical duty to protect society as well.[79]

In recent years, medical and mental health professions have also been the subject of increasing judicial scrutiny. Courts have subjected

76. "If the conduct of the actor has brought him into a human relationship with another, of such character that sound social policy requires either some affirmative action or some precaution on his part to avoid harm, the duty to act or take the precaution is imposed by law." Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886 (1934). *See also* Keeton, *Roger Traynor and the Law of Torts*, 44 S. CAL. L. REV. 1045 (1971); Tobriner, *Retrospect: Ten Years on the California Supreme Court*, 20 U.C.L.A. L. REV. 5 (1972).

77. W. PROSSER, THE LAW OF TORTS 325-26 (4th ed. 1971). *See* Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 434, 551 P.2d 334, 342, 131 Cal. Rptr. 14, 22 (1976); Dillon v. Legg, 68 Cal. 2d 728, 734, 441 P.2d 912, 916, 69 Cal. Rptr. 72, 76 (1968).

78. Leading examples of this trend include Weirum v. R.K.O. Gen. Inc., 15 Cal. 3d 40, 539 P.2d 36, 123 Cal. Rptr. 468 (1975) (radio station liable because it was foreseeable that a contest would cause drivers to disregard highway safety); Dillon v. Legg, 68 Cal. 2d 728, 441 P.2d 912, 69 Cal. Rptr. 72 (1968) (rejecting the "impact rule" and "zone of danger test" to allow recovery for negligent infliction of emotional distress); Rowland v. Christian, 69 Cal. 2d 108, 443 P.2d 561, 70 Cal. Rptr. 97 (1968) (rejecting common law licensee, invitee, and trespasser classifications for determining the liability of a landowner for injuries). A microcosm of the evolution of this expanded duty concept can be found in the "key in the car" cases, which ultimately imposed liability on the owner of an unlocked car for the acts of its thief. *See, e.g.*, Hergenrether v. East, 61 Cal. 2d. 440, 393 P.2d 164, 39 Cal. Rptr. 4 (1964) (imposing liability for unlocked car); Richardson v. Ham, 44 Cal. 2d 772, 285 P.2d 269 (1955) (unlocked bulldozer). *But see* Richards v. Stanley, 43 Cal. 2d 60, 271 P.2d 23 (1954) (rejecting liability for unlocked car).

79. *See* Sidel, *Confidential Information and the Physician*, 264 N. ENGL. J. OF MED. 1133, 1134 (1961). *See also* AMERICAN PSYCHOLOGICAL ASSOCIATION, CASEBOOK ON ETHICAL STANDARDS OF PSYCHOLOGISTS (1967). Principle 1(c) of the Psychologist's Code of Ethical Standards requires that "[a]s a practitioner, the psychologist knows that he bears a heavy social responsibility because his work may touch intimately the lives of others." *Id.* at 64.

them to new duties[80] and have granted their patients new protections.[81] In our complex society, power and duty have, for the health professionals, become correlative.[82] The basic social policy at the heart of *Tarasoff* is the protection of public safety.[83] Although all members of society may have an ethical duty to prevent violence, the law requires only those with special powers, special skills, and special knowledge to discharge a legal duty. As the *Tarasoff II* court explained:

> In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest.[84]

Countervailing Considerations

The *Tarasoff* court found that the policy of protecting public safety required the imposition of a psychotherapists' duty to protect third persons from their patients. Critics of the decision argue that the duty should not be imposed because of the public policy of fostering effective psychotherapy.

Disclosure and Confidentiality

Ultimately, the recognition of a psychotherapist's duty is a balancing process among the public interests of safety, effective treatment of mental illness, and protecting the rights of patients to privacy.[85] Opponents of the *Tarasoff* decision argue that imposing liability for

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80. For example, note the requirement of informed consent. *See* Slater v. Kehoe, 38 Cal. App. 3d 819, 113 Cal. Rptr. 790 (1974); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). *See generally* Kessenick & Mankin, *Medical Malpractice: The Right to be Informed,* 8 U.S.F. L. REV. 261 (1973).

81. In the psychiatric context, the most dramatic extension of patient protection is the so-called "right to treatment." *See, e.g.,* Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, remanded in part,* Wyatt v. Alderholt, 503 F.2d 1305 (5th Cir. 1974); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). Judicial surveillance is not surprising in light of the shocking ignorance of patient's rights that prevails in the mental health professions. *See, e.g.,* L. TANCREDI, J. LIEB, & A. SLABY, LEGAL ISSUES IN PSYCHIATRIC CARE vii (1975).

82. Fleming & Maximov, *supra* note 4 at 1029.

83. Public interest in the possible threat posed by the mentally ill is keen. *See* NEWSWEEK, June 4, 1973 at 69.

84. 17 Cal. 3d at 446, 551 P.2d at 347-48, 131 Cal. Rptr. at 26.

85. *Id.* at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26.

failure to warn or take other protective measures will undermine and effectively destroy the benefits of psychotherapy.[86]

The decision to seek psychological aid is not an easy one. Our society has an unpleasant tendency to stigmatize those who seek such assistance as crazy, dangerous people. One who seeks psychotherapy necessarily worries about his reputation.[87] In many cases the activating cause in risking the stigma by seeking psychiatric help is a desire to avoid conduct that could subject one to social exile or criminal and civil penalties of a harsh nature.[88]

Unquestionably, a certain degree of confidentiality is necessary for effective treatment.[89] "The very essence of psychotherapy is confidential personal revelations about matters which the patient is and should be normally reluctant to discuss."[90] Understandably this process is not an easy one and thus a large portion of early therapy is aimed at developing a relationship of trust between the therapist and the patient.[91] If the patient thought that his secrets would not be held in the strictest confidence, he might not make the full disclosure that is the *sine qua non* of traditional psychotherapy.[92]

Critics of *Tarasoff* argue that requiring psychotherapists to give warnings or take other action to protect threatened persons would undermine confidentiality and deter some people who might otherwise seek therapy, as well as destroy the effectiveness of treatment for those who nonetheless seek help. As expressed by Justice Clark in his dissent in *Tarasoff:*

> [T]he duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry. Many people, potentially violent — yet susceptible to treatment — will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment; and, forcing the psychiatrist to violate

86. *Id.* at 458-60, 551 P.2d at 358-60, 131 Cal. Rptr. at 38-40 (Clark, J., dissenting).

87. *See generally* Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications,* 10 WAYNE L. REV. 609, 617 (1964); Slovenko, *Psychiatry and a Second Look at Medical Privilege,* 6 WAYNE L. REV. 175, 188 (1960) [hereinafter cited as Slovenko].

88. *See generally* Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute,* 36 CONN. B.J. 175, 188 (1962) [hereinafter cited as Goldstein & Katz]; Slovenko *supra* note 87 at 187 (1960).

89. *See In re* Lifschutz, 2 Cal. 3d 415, 422, 467 P.2d 557, 560-61, 85 Cal. Rptr. 829, 832-33 (1970).

90. Slovenko, *supra* note 87 at 184-85.

91. *See, e.g.,* Dawidoff, *The Malpractice of Psychiatrists,* (1966) DUKE L.J. 696, 704. *See also* Goldstein & Katz, supra note 88 at 179.

92. *See* CAL. EVID. CODE § 1014, Comment, Senate Committee on Judiciary (West 1966); Goldstein & Katz, *supra* note 88 at 179.

> the patient's trust will destroy the interpersonal relationship by which treatment is effected.[93]

The net result, Justice Clark warns, will surely be "increased violence."[94]

The privileges that protect, to varying extents, the confidential communications between attorney and client, doctor and patient, priest and penitent, and therapist and patient, are the result of a delicate balancing process between competing interests of society.[95] With the possible exception of the clergyman-penitent privilege,[96] these privileges are subject to statutory exceptions in which the interest in safety, the judicial system's needs, or society's other requirements are considered greater than the need for confidentiality. Even the attorney-client privilege, perhaps the oldest and most assiduously protected privilege, is subject to several exceptions.[97]

The privilege that expressly protects confidential communications between a therapist and his patient is relatively new in most states. Although doctors and psychotherapists place confidentiality at the forefront of their ethical duties,[98] originally the only legal protection of confidentiality existed under the doctor-patient privilege for psychiatrists, because they had medical degrees.[99] Today most states by statute or modern common law recognize some form of a psychotherapist-patient privilege.[100]

In California, section 1014 of the Evidence Code establishes the privilege.[101] The accompanying Senate Committee Comment empha-

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93. 17 Cal. 3d at 460, 551 P.2d at 360, 131 Cal. Rptr. at 40 (1976) (Clark, J., dissenting).

94. *Id.* at 463, 551 P.2d at 362, 131 Cal. Rptr. at 42.

95. *See* 8 J. WIGMORE, EVIDENCE § 2285 (McNaughton rev. 1961) [hereinafter cited as WIGMORE].

96. CAL. EVID. CODE §§ 1030-1034 (West 1966).

97. *See* CAL. EVID. CODE 956 (West 1966) (crime or fraud), CAL. EVID. CODE § 857 (West 1966) (parties claiming through deceased client), CAL. EVID. CODE § 958 (West 1966) (breach of duty arising out of lawyer-client relationship) and CAL. EVID. CODE §§ 959-61 (West 1966) (deceased client) and CAL. EVID. CODE § 962 (West 1966) (joint clients). *See generally* WIGMORE, *supra* note 95, at 527.

98. See AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 in 164 J.A.M.A. 887 (1957); AMERICAN PSYCHOLOGICAL ASSOCIATION, CASEBOOK ON ETHICAL STANDARDS OF PSYCHOLOGISTS, 66 (1967), Principle 6: "Safeguarding information about an individual that has been obtained by the psychologist in the course of his . . . practice . . . is a primary obligation of the psychologist."

99. *See, e.g.*, Slovenko, *supra* note 87.

100. *See* Annot. 44 A.L.R.3d 24 (1972). For a recent decision establishing the privilege, see Allred v. State, 554 P.2d 411 (Alas. 1976).

101. [T]he patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist . . . . " CAL. EVID. CODE § 1014 (West 1966).

sizes the importance of confidentiality in treatment, reporting that some patients refused treatment because confidentiality could not be assured.[102]

The privilege establishes a limited right of confidentiality for the patient. The right has a constitutional foundation based on the right of privacy.[103] The patient may enforce this right with a cause of action based on breach of confidentiality.[104]

Despite the strong justification for the privilege, exceptions have been created in circumstances in which the need for confidentiality was superseded by interests deemed more important.[105] The largest exception is perhaps the patient-litigant exception.[106] There is no privilege if the confidential communication is relevant to an issue tendered in civil litigation by the patient concerning his mental or emotional condition. The exception withstood a constitutional attack by a psychiatrist in the case of *In re Lifschutz*,[107] in which the California Supreme Court held that despite the constitutional underpinnings of the privilege, state interference with confidentiality was not flatly prohibited.

Almost all privileges have exceptions that have been established to protect the public from crime, fraud,[108] or other dangers.[109] For

102. CAL. EVID. CODE § 1014, Comment, Senate Committee on the Judiciary (West 1966).

103. *See, e.g., In re* Lifschutz, 2 Cal. 3d 415, 431-32, 467 P.2d 557, 567-68, 85 Cal. Rptr. 829, 839-40 (1970), in which the court, citing Griswold v. Connecticut, 381 U.S. 479 (1965), found that a patient's interest in confidentiality was supported by the emerging constitutional right to privacy. The court further held, however, that the psychotherapist could claim no such constitutional support for himself. 2 Cal. 3d at 423-24, 467 P.2d at 561-62, 85 Cal. Rptr. at 833-34.

104. Liability for breach of the doctor-patient privilege was recognized in Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793 (N.D. Ohio 1965); Clark v. Geraci, 208 N.Y.S.2d 564 (1960). *See* CAL. WELF. & INST. CODE § 5330 (West 1972) providing treble damages for violation of confidence while acting pursuant to the Lanterman-Petris-Short commitment statute. *See also* Annot., 20 A.L.R.3d 1109 (1968).

105. See CAL. EVID. CODE § 1016 (West 1966) (patient-litigant), CAL. EVID. CODE § 1018 (West 1966) (crime or tort), CAL. EVID. CODE § 1025 (West 1966) (proceedings to establish competence), CAL. EVID. CODE § 1026 (West 1966) (required reports), CAL. EVID. CODE § 1027 (West Supp. 1977) (patient victim of crime or child under 16 years of age).

106. CAL. EVID. CODE § 1016 (West 1966).

107. 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970).

108. *E.g.*, CAL. EVID. CODE § 981 (West 1966) (marital communication), CAL. EVID. CODE § 997 (West 1966) (physician-patient), CAL. EVID. CODE § 1018 (West 1966) (psychotherapist-patient), and, of course, CAL. EVID. CODE § 956 (West 1966) lawyer-client). The lawyer-client exception is not a recent innovation and has been often litigated. *See, e.g.*, United States v. Friedman, 445 F.2d 1076 (9th Cir. 1971). *See generally* 81 AM. JUR. 2d, Witnesses § 172 (1976); Annot., 2 A.L.R.3d 861 (1965); Annot., 125 A.L.R. 508 (1940).

109. *See, e.g.*, Hague v. Williams, 37 N.J. 328, 181 A.2d 345 (1962); Berry v. Moench, 8 Utah 191, 331 P.2d 814 (1958).

example, an exception has long been recognized to the doctor-patient privilege in the familiar contagious disease situation. The Nebraska case of *Simonsen v. Swenson*[110] is illustrative. In that case, a doctor diagnosed syphilis, warned his patient of its contagious nature, and asked him to leave his present hotel accommodations. Later, when the doctor learned the patient had not moved, he warned the hotel owners of his condition, and the patient was evicted.[111] The court, in holding for the doctor in a suit for breach of confidence, recognized the doctor's duty to those who might have been endangered. "No patient can expect that if his malady is found to be of a dangerously contagious nature he can still require it to be kept secret from those to whom . . . such disease would be transmitted."[112] The public safety exception to confidentiality is accepted by the Code of Medical Ethics, which allows disclosure that is "necessary in order to protect the welfare of the individual or of the community."[113]

Earlier, an analogy was made between the contagious disease situation and the *Tarasoff* situation.[114] The analogy is apt here because the public safety is equally threatened by a dangerous patient. An exception to the privilege in these situations is accepted as part of the ethical duties of a psychologist.[115]

The *Tarasoff* court in balancing the countervailing interests of public safety and confidentiality relied upon the legislative judgment reflected in section 1024 of the California Evidence Code.[116] The section provides that there is no privilege

> if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another, and that disclosure of the communication is necessary to prevent the threatened danger.[117]

The accompanying Law Revision Commission Comment states that although "this exception might inhibit the relationship between the patient and his psychotherapist to a limited extent, it is essential that appropriate action be taken if the psychotherapist becomes convinced . . . that the patient is a menace to himself or others . . . ."[118]

110. 104 Neb. 224, 177 N.W. 831 (1920).

111. The court and doctor apparently believed syphilis to be contagious in the same manner as a normal infectious disease.

112. 104 Neb. at 228, 117 N.W. at 832.

113. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 (1957).

114. See notes 71-74 & accompanying text *supra*.

115. See AMERICAN PSYCHOLOGICAL ASSOCIATION, CASEBOOK ON ETHICAL STANDARDS FOR PSYCHOLOGISTS, 66 (1967), in which disclosure is authorized if there is a "clear and imminent danger to an individual or to society."

116. 17 Cal. 3d at 440-41, 551 P.2d at 346-47, 131 Cal. Rptr. at 26-27.

117. CAL. EVID. CODE § 1024 (West 1966).

118. CAL. EVID. CODE § 1024, Comment, Law Revision Commission (West 1966).

The fact that the legislature expressly allows disclosure indicates a legislative recognition that interests other than confidentiality can be paramount.[119] The court was careful to note that it did not rely upon the Evidence Code to establish liability but solely to indicate legislative intent on the degree of confidentiality desirable.[120]

The Impact of Tarasoff

The dire warnings of *Tarasoff's* critics are highly speculative. No definitive evidence has been offered to support the allegation that psychotherapy would be undermined.[121] Exceptions to confidentiality are not new, even to the the psychotherapy privilege. Indeed, until comparatively recently, most states did not even have a special psychotherapy privilege.[122] That psychotherapy flourished with no privilege or only a qualified privilege is unquestioned.[123] The *Tarasoff* court noted that one of the largest exceptions, the patient-litigant exception upheld in the *Lifshutz* case, has not seemed to deter treatment.[124] The ethical duties of both doctor and psychologist allow disclosure to protect third parties, and presumably such disclosures are being made.[125]

119. *Id.* at 441 n. 13, 551 P.2d at 347, 131 Cal. Rptr. at 27.

120. 17 Cal. 3d at 441 n. 13, 551 P.2d at 347, 131 Cal. Rptr. at 27. The majority's use of this section has been criticized. *See* Tarasoff v. Regents of the Univ. of Cal. *Id.* at 456, 551 P.2d at 357, 131 Cal. Rptr. at 37 (Clark, J., dissenting); Note, *The Dangerous Patient Exception and the Duty to Warn: Creation of a Dangerous Precedent?*, 9 U. CAL. D.L. REV. 549, 557-62 (1976).

121. Justice Clark's dissent in *Tarasoff* cites a survey that indicated that 5 out of 7 persons interviewed said they would be less likely to make full disclosure to a psychiatrist in the absence of an assurance of confidentiality. 17 Cal. 3d at 459 n. 3, 551 P.2d at 359, 131 Cal. Rptr. at 39. The survey is found in *Comment, Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226 (1962). Aside from the basic unreliability of this type of poll (which draws conclusions from what one says he will do in a certain situation), the survey is inconclusive for two reasons. First, the sample is limited to fewer than 108 people, with no indication that they were the type likely to seek psychotherapy. *Id.* at 1262. Secondly, the study framed its question as though there were *no* privilege at all. This situation is not at issue here and would certainly be significantly more threatening than a specialized exception to an existing privilege.

122. See notes 99-100 & accompanying text *supra.*

123. "[W]e cannot blind ourselves to the fact that the practice of psychotherapy has grown, indeed flourished, in an environment of a non-absolute privilege." *In re* Lifschutz, 2 Cal. 3d 415, 426, 467 P.2d 557, 85 Cal. Rptr. 829, 836 (1970). "I must admit that in my private psychiatric practice I have never been aware of being hampered by the fact that Maryland doesn't have the physician-patient privilege. No patient has ever raised the issue in my office." R. SLOVENKO, PSYCHOTHERAPY, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATIONS 52 n. 17 (1966), quoting M. GUTTMACHER, THE MIND OF THE MURDERER 173 (1960).

124. 17 Cal. 3d at 440 n. 12, 551 P.2d at 346, 131 Cal. Rptr. at 26.

125. See notes 113-15 & accompanying text *supra.*

Indeed, there are good reasons to expect the impact of *Tarasoff* to be minimal.

Unlike the first opinion, the second *Tarasoff* decision does not dogmatically require warnings to threatened individuals. Rather, any one of a number of precautions may satisfy the standard of care.[126] In many situations, the psychotherapist may be able to convince the patient to submit to voluntary hospitalization, which entails no breach of confidentiality.[127] If the patient does not act voluntarily, the psychotherapist may decide that involuntary commitment under the Lanterman-Petris-Short Act is appropriate. Because that Act has even stricter safeguards than the general psychotherapist privilege, the patient's interest in confidentiality would be adequately protected.[128]

The impact of *Tarasoff* will be minimal even in situations in which an actual warning may be necessary. Few people would seriously expect any professional to remain inactive and silent in the face of serious threats of dangerous conduct. Even Ralph Slovenko, one of the earliest and most energetic supporters of the psychotherapist privilege, acknowledged that

> the general public and putative patients will not lose faith in the doctor as a keeper of secrets when, in cases of emergency, he acts contrary to strict confidentiality. Sooner or later, the patient himself will come to realize that the doctor has acted in his interest . . . .[129]

As Karl Menninger put it, "[N]o patient has a right to exploit the confidential relationship offered by the physician to make the physician a *particeps crimines*."[130] It is reasonable to expect a professional to act for the protection of others; indeed, his code of ethics requires him to do so.[131] The *Tarasoff* exception, probably more limited than other exceptions, is supported by common sense. The decision does not require "routine revelations" and indeed requires the therapist to use discretion to protect the patient's privacy.[132] When a psychotherapist seriously believes his patient is a threat to others, however, he is obli-

126. 17 Cal. 3d at 431, 439, 441, 551 P.2d at 340, 345, 347, 131 Cal. Rptr. at 20, 25, 27.

127. See notes 54-55 & accompanying text *supra*.

128. CAL. WELF. & INST. CODE §§ 5328-5328.9 (West 1972 & Supp. 1977). The Tarasoff court discusses the applicability of these sections. 17 Cal. 3d at 443, 551, P.2d at 348-49, 131 Cal. Rptr. at 28-29.

129. Slovenko, *supra* note 87 at 198.

130. K. MENNINGER, A MANUAL FOR PSYCHIATRIC CASE STUDY, 36-37 (2d ed. 1962). "If a patient tells a doctor in confidence that he has brought a time bomb into the hospital and hidden it under the bed of one of the other patients, it is a strange doctor indeed who would feel that this professional confidence should not be violated." *Id.*

131. See notes 113-15 & accompanying text *supra*.

132. 17 Cal. 3d at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

gated to act on that belief. He is not limited solely to divulging confidences but may choose the most appropriate and least disruptive course of action.[133]

Ultimately the process of balancing is involved. The court in *Tarasoff* weighed the policy factors and found that "[t]he protective privilege ends where the public peril begins."[134]

The Prediction of Violent Conduct

"[C]onfronted by the majority's new duty, the psychiatrist must instantaneously calculate potential violence from each patient on each visit," charged Justice Clark in his dissent.[135] Indeed, this concern probably underlies the virulence of the psychiatric community's denunciation of *Tarasoff*. Critics claim that the holding is unworkable because a psychotherapist cannot accurately predict if a patient is going to be violent. Because such violence is unforeseeable, psychotherapists will play it safe and tend to overpredict violence with a resultant overcommitment of patients.

Dissenting Justices Clark and McComb point to a large body of literature showing little or no correlation between mental illness and violence,[136] as well as to studies showing consistent inaccuracies in prediction.[137] They argue that psychiatrists have no more proven ability to predict violent behavior than anyone else.[138] To place the

133. *Id.* at 431, 441, 551 P.2d at 340, 347, 131 Cal. Rptr. at 20, 27.

134. *Id.* at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27. "The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved." *Id.* at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26.

135. 17 Cal. 3d at 462, 551 P.2d at 361, 131 Cal. Rptr. at 41. (Clark, J., dissenting).

136. *See, e.g., Hearings Before the Subcommittee on Constitutional Rights of the Senate Judiciary Committee,* 91st Cong., 1st and 2d sess. (1969-1970) at 277; Steadman & Cocozza, *We Can't Predict Who is Dangerous,* 8 PSYCHOLOGY TODAY 32, 33 (Jan. 1975) [hereinafter cited as Steadman & Cocozza]; Steadman & Keveles, *The Community Adjustment and Criminal Activity of the Baxtrom Patients: 1966-1970,* 129 AM. J. OF PSYCHIAT. 304 (1972).

137. *See, e.g.,* People v. Burnick, 14 Cal. 3d 306, 327, 535 P.2d 352, 121 Cal. Rptr. 488 (1975); Diamond, *The Psychiatric Prediction of Dangerousness,* 123 U. PA. L. REV. 439, 444-47 (1974) [hereinafter cited as Diamond]; Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CALIF. L. REV. 693, 712-16 (1974) [hereinafter cited as Ennis & Litwack]. *But see,* Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness,* 18 CRIME & DELIN. 371 (1972) [hereinafter cited as Kozol, Boucher & Garofalo]; Wenk, Robison & Smith, *Can Violence Be Predicted?,* 18 CRIME & DELIN. 393 (1972) [hereinafter cited as Wenk, Robison & Smith]. *See generally,* J. RAPPEPORT, THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL (1967) [hereinafter cited as Rappeport].

138. "[P]sychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals." *Hearings on*

burden of the *Tarasoff* duty upon psychotherapists, critics claim, will be unworkable because no standard of foreseeability can be established.

The critics of *Tarasoff* fear that rather than facing the possibility of heavy civil sanctions or the wrath of the public, the psychotherapist will err on the side of safety and tend to overcommit his patients.[139] This process will be exacerbated, the critics predict, by the *Tarasoff* court's subsidiary holding that the defendants as employees of a public entity were protected by governmental immunity, which cloaked all acts relating to commitment under the Lanterman-Petris-Short Act.[140]

Judicial recognition was given to these claims, the dissenters argue, in the case of *People v. Burnick*.[141] In that case, the state supreme court was asked to decide whether the standard of proof in commitment proceedings for mentally disordered sex offenders was the civil standard of preponderance of the evidence or the much stricter criminal standard of proof beyond a reasonable doubt. In holding that the criminal standard should apply the court presented an indictment of psychiatric inaccuracy and tendency to overcommit patients.[142] Justice Mosk, in his concurrence in *Tarasoff II*, argued that the *Tarasoff* holding was offensive to the findings in *Burnick:*

> [T]he similarity in issues is striking: in *Burnick* we were likewise called upon to appraise the ability of psychiatrists to predict dangerousness, and while we declined to bar all such testimony . . . we found it so inherently untrustworthy that we would permit confinement even in a so-called civil proceeding only upon proof beyond a reasonable doubt.[143]

Grave though the charges were, none of them were in issue in *Tarasoff* because the defendants *did* in fact predict that Poddar posed a serious danger of violence to another and acted on the prediction. The issue of foreseeability was reserved for later cases.[144] Yet the

the Constitutional Rights of the Mentally Ill Before Subcommittee on Constitutional Rights of the Senate Judiciary Committee, 91st Cong., 1st and 2d sess. (1969-1970) at 277-78. One major problem is a lack of systematic knowledge in the field of psychiatry; *see, e.g.,* Ennis & Litwack, *supra* note 137 at 733; Diamond, *supra* note 137 at 451-52; Wenk, Robison & Smith, *supra* note 137 at 401.

139. *See, e.g.,* Diamond, *supra* note 137 at 445; Fleming & Maximov, *supra* note 4 at 1044-45; Steadman & Cocozza, *supra* note 136 at 35. Ennis & Litwack, *supra* note 137 at 719-34 suggest several factors behind the general tendency of psychiatric overprediction including orientation and training, context of patient interviews and relationship, and shortness of interviews.

140. 17 Cal. 3d at 448-49, 551 P.2d at 351-52, 131 Cal. Rptr. at 42.

141. 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975).

142. *Id.* at 325-28, 535 P.2d at 564-67, 121 Cal. Rptr. at 500-05.

143. 17 Cal. 3d at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting).

144. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

dissenters paint a grim picture. Although the statistical studies of violence prediction are not as monolithically disheartening as suggested,[145] they appear to raise serious doubts about the workability of *Tarasoff*. How relevant are these studies to the *Tarasoff* context?

The Relevance of Prediction Surveys

The context in which the studies relied upon by the critics were made should be noted. Basically, the critics cited two types of study: either (1) the track records of psychiatric advisors to courts and mental facilities in criminal and civil commitment contexts or (2) large statistical surveys attempting to pinpoint the causes of violence. The relevance of these studies to the *Tarasoff* context is questionable. The relationship among the psychiatrist, the allegedly dangerous person, and the authorizing authority, such as a court, mental facility or university, differs significantly from the *Tarasoff* context.

In these studies, the psychiatrist usually has a closer relationship with the court or the mental facility he is advising than with the patient. Often, his responsibility to the court and his impetus to retain the confidence of the judge may be major influences in the play it safe strategy that leads to over-prediction.[146] It may seem safer to the consulting psychiatrist, as an officer of the court or a state official, to commit too many than to run the risk of incurring official displeasure by committing too few.[147] His relationship with the would-be patient is either the short-lived relationship of a court appointed psychiatrist or the distant relationship of the mental facility director to his confinee.[148] Divided loyalties, official responsibilities and a distant impersonal relationship with the patient distinguish this type of psychiatrist from one acting within the *Tarasoff* context.

Statistical attempts to develop an empirical theory of violence have little relevance to the *Tarasoff* situation.[149] Statistical studies of large pools of people over long periods of time seek identifiable environmental and social characteristics in population groups that

145. *See* RAPPEPORT, *supra* note 137, Kozol, Boucher & Garofalo, *supra* note 137 at 377, 392.

146. Steadman & Cocozza, *supra* note 136 at 35.

147. For discussion of the effect of divided loyalties in the commitment process, *see*, Shestack, PSYCHIATRY AND THE DILEMMAS OF DUAL LOYALTIES, MEDICAL, MORAL, AND LEGAL ISSUES IN MENTAL HEALTH CARE 7 (F. Ayd ed. 1974). *See generally* Hollender, *The Psychiatrist and the Release of Patient Information*, 116 AM. J. PSYCHIAT. 828 (1960).

148. Ennis & Litwack, *supra* note 137 at 719-34 stressed the context in which the relationship takes place as a factor in overprediction. The mental hospital environment, the patient's mental hospital dress, and short interviews at widely spaced intervals influence the predicting psychiatrist.

149. See Ayres & Holbrook, *supra* note 5 at 685-86.

would indicate potential dangerousness.[150] By contrast, the psychotherapist in the *Tarasoff* situation must evaluate the conduct and history of his patient to determine whether the patient presents a serious threat to a third person.

Two factors present in the *Tarasoff* situation are often not present in these studies. First, and very importantly, is the presence of a specific threat. Even without the *Tarasoff* duty, psychotherapists faced with serious threats generally act preventively.[151] Second, a thorough knowledge of the patient's history and the close working relationship between the therapist and his patient are often missing in the violence studies.[152] A factor most psychiatrists find strongly indicative of potential violence is a history of aggressive acts. If such history is coupled with a specific threat, a deadly combination exists which a reasonably skilled therapist must take seriously.[153]

The *Burnick* case is also distinguishable because of its context. The court in *Burnick* was deciding the standard of proof in an indefinite commitment proceeding, a proceeding in which due process considerations play a major role.[154] The court in *Tarasoff* noted that the issue was not commitment but "whether the therapist should take any steps at all to protect the threatened victim."[155] Because most of the options suggested by the *Tarasoff* decision do not involve the constitutional rights of the patient raised in *Burnick*,[156] that case is not controlling. Significantly the *Burnick* court did not bar the psychiatric testimony of violence potential; rather, the court made it subject to a high level of proof. Presumably these predictions will remain the gravamen of a commitment hearing where the criteria for commitment remains "dangerousness to others."

The relationship of the psychiatrist to the court in the *Burnick* situation is absent in the *Tarasoff* context. The therapist in a *Tarasoff* situation has no conflicting court or state relationship to protect by

150. *See, e.g.*, RAPPEPORT, *supra* note 137.

151. Ochberg & Brown, *Mental Health and the Law: Partners in Advancing Human Rights*, 123 U. PA. L. REV. 491, 506 (1974) [hereinafter cited as Ochberg & Brown).

152. See notes 136-38 *supra*.

153. *See*, S. HALLECK, THE POLITICS OF THERAPY 162 (1971); Mechanic, *supra* note 51 at 144 (1969); Kozol, Boucher & Garofalo, *supra* note 137 at 384; Ochberg & Brown, *supra* note 151.

154. 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975).

155. 17 Cal. 3d 439, 551 P.2d at 346, 131 Cal. Rptr. at 26.

156. The due process considerations raised by commitment proceedings arise from the loss of liberty from state imposed incarceration. If the psychotherapist warns the authorities or an intended victim or persuades the patient to submit to voluntary hospitalization, there is no such state imposed denial of liberty. If the psychotherapist acts pursuant to the Lanterman-Petris-Short commitment statute, the patient is protected by built in procedural safeguards. See notes 169-73 & accompanying text *infra*.

recommending commitment;[157] instead he has a close relationship with his patient and a range of professionally appropriate alternatives for action if he believes a genuine danger exists.[158]

Prediction and Psychiatric Roles

For years, psychiatrists as advisors to the judicial system have fostered the belief that they are the only professionals who can predict violence. Courts, parole boards, legislatures, and the public at large have taken their word for it.[159] Now, when this belief has become a double-edged sword, they are retreating from their long held position.

This inconsistent position leads to some interesting anomalies. Dr. Lee Coleman, writing to the supreme court after a rehearing was granted in the *Tarasoff* case, said: "It is hard for me to understand how the psychiatric community can have it both ways — to be free of an obligation to warn on the basis of *inability* to predict dangerousness, and yet to have the authority to incarcerate patients on the basis of an *ability* to predict dangerousness."[160] Another commentator noted that the logical extension of the latest psychiatric position would require the exclusion of psychiatric testimony on the reasonable probability of violent propensities of a given individual in *any* court proceeding.[161] Indeed, barring this type of psychiatric testimony in a commitment proceeding would make more sense than in the *Tarasoff* context because commitment directly threatens individual liberty.[162]

As a practical matter, psychotherapists not only make predictions for the courts but can and must make predictions of patients' probable conduct each working day.[163] With a seriously disturbed patient, a psychotherapist must of necessity evaluate probable dangers to himself and others. To claim that *Tarasoff* will force psychotherapists to evaluate the danger of every patient every day is to ignore the realities of psychotherapy that require such evaluations already.

The *Tarasoff* duty may be seen as a necessary corollary to the psychotherapist's potential power to cause the incarceration of his pa-

157. See notes 146-48 & accompanying text *supra.*

158. See note 25 & accompanying text *supra.*

159. *See, e.g.,* Ayres & Holbrook, *supra* note 5 at 686-87, Note, *Tarasoff and the Psychotherapist's Duty to Warn,* 12 SAN DIEGO L. REV. 932, 950-51 (1975).

160. Letter to California Supreme Court, March 11, 1975, *quoted* in Ayres & Holbrook, *supra* note 5 at 686.

161. Ayres & Holbrook, *supra* note 5 at 687. A more serious suggestion is discussed in People v. Burnick, 14 Cal. 3d 306, 328 n.19, 535 P.2d 352, 366, 121 Cal. Rptr. 488, 502 (1975).

162. See notes 154-55 & accompanying text *supra.*

163. *See, e.g.,* Ayres & Holbrook, *supra* note 5 at 699-700; Morris, *Psychiatry and the Dangerous Criminal,* 41 S. CAL. L. REV. 514, 529-36 (1968).

tient.[164] A warning or an attempt to convince a patient to submit to voluntary hospitalization could be an equally effective step, less onerous than incarceration. Indeed, if the psychotherapist has a duty to act and the patient knows it, voluntary commitment may be the more viable alternative.[165]

The Danger of Over-Commitment

The contention that *Tarasoff* will lead to over-commitment is based upon the assumption that psychotherapists are unable to evaluate the potential for danger in their patients. The critics of *Tarasoff* documented this assumption with studies of questionable relevance.[166] The danger of over-commitment, like the danger of massive breaches of confidentiality, appears speculative.

Any potential for over-commitment is limited by the presence of a variety of procedural safeguards against casual commitment. The *Burnick* case, establishing a high standard of proof in judicial indefinite commitment cases, makes it difficult for a psychiatrist to over-commit such patients.[167]

The Lanterman-Petris-Short Act[168] establishes guidelines for involuntary commitment and establishes a comprehensive scheme of procedural safeguards against over-commitment. The involuntary commitment sections create a graduated series of confinement periods from seventy-two hours to ninety days. As the period is increased, more people are brought into the evaluation process and a higher degree of proof is required.[169] Patients are advised of their rights to counsel and to *habeas corpus* proceedings and are afforded a full court hearing if they are held for more than fourteen days.[170] The patient's psychotherapist, if he is not a county designate, does not even have the power to cause the initial commitment.[171] Although designated psychotherapists and staff members of the evaluation facility are granted immunity from civil suit,[172] statutory penalties are provided by the Act

164. Ayres & Holbrook, *supra* note 5 at 693-94.

165. This analysis may be especially true in the "cry for help" cases. See notes 54-55 & accompanying text *supra*.

166. See notes 146-53 & accompanying text *supra*.

167. 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975).

168. CAL. WELF. & INST. CODE §§ 5000-5401 (West 1972 & Supp. 1976).

169. See notes 61-62 & accompanying text *supra*. For the practical operation of the Act, see Note, *Civil Commitment of the Mentally Ill in California — The Lanterman-Petris-Short Act*, 7 LOY. L.A.L. REV. 93 (1974).

170. See notes 60 & 62 & accompanying text *supra*.

171. See notes 61 & 63 & accompanying text *supra*.

172. See note 63 & accompanying text *supra*.

to discourage wanton commitment.[173] The Act thus deters casual commitment.

Unlike the typical civil commitment situation in which the therapist acts as an advisor to the court, the psychotherapist's more extensive patient relationship in the *Tarasoff* context should limit tendencies towards over-commitment. If he has a private practice involving therapeutic relationships with his patients, he has an interest in preserving his effectiveness and reputation. In most cases, a warning to the intended victim or the authorities will be not only the least disruptive course of conduct but the best course in terms of his effectiveness and reputation. A psychotherapist's practice would be severely undermined if it became known that he was rashly committing his patients. Finally, any tendency towards over-commitment should dissipate as psychotherapists realize the limited applicability of the *Tarasoff* duty implicit in the requisite standard of care.

Establishing a Standard of Care

The *Tarasoff* court established a duty for the psychotherapist to use reasonable care to protect another if he "determines or pursuant to the standards of his profession should determine that his patient presents a serious danger of violence to another."[174] The court held psychotherapists to a professional standard similar to the physician's malpractice standard.[175] Perfect performance is not required; there will be no liability for a mere error of judgment.[176] The court limited the duty to those situations in which a serious danger of physical harm to another exists. It specifically noted that no routine disclosures are required.[177] The court's discussion of the requisite standard of care, as well as the unique facts of the *Tarasoff* case, indicate that the duty will have limited applicability.

Foreseeability, not in issue in *Tarasoff*,[178] is an important consid-

173. For example, CAL. WELF. & INST. CODE § 5255 (West 1972 & Supp. 1977) provides damages for excessive detention. Liability for false statements leading to involuntary confinement by an undesignated person is provided in CAL. WELF. & INST. CODE § 5150 (West 1972 & Supp. 1977). The immunity provisions do not apply to a psychotherapist who is not designated by the county or who is not a member of the evaluating staff of the mental facility. A non-designated therapist could be found liable for false imprisonment. *See* Maben v. Rankin, 55 Cal. 2d 139, 358 P.2d 681, 10 Cal. Rptr. 353 (1961).

174. Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

175. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25. See note 191 & accompanying text *infra*.

176. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

177. *Id.* at 431, 439, 551 P.2d at 340, 345, 131 Cal. Rptr. at 20, 25.

178. *Id.* at 435, 439, 551 P.2d at 343, 345, 131 Cal. Rptr. at 23, 25.

eration in determining breach of duty and proximate cause.[179] Thus, defining a specific standard of care that fulfills the *Tarasoff* duty and establishing proximate cause requires a determination of under what circumstances a reasonable psychotherapist should foresee a serious danger from his patient. The applicable standard of foreseeability lies at the heart of much of the anxiety concerning *Tarasoff*. Such a standard must take into account the interests in public safety, confidentiality, and effective psychotherapy. The balancing process is a difficult one. Analogous situations provide some aid in defining such a standard.

In Search of a Standard: Analogous Situations

A patient at a mental hospital or nursing home violently assaults a nurse. The nurse sues the hospital and the doctor for failure to warn of the patient's violent propensities. This fact pattern, remarkably similar to *Tarasoff*, has faced New York courts.[180] These courts have consistently rejected a standard of care based on what a doctor should know of a patient's propensities because they felt it would amount to subjecting the doctor to liability for an error in judgment. Instead, their standard has imposed actual knowledge by the doctor of the patient's dangerous condition as a prerequisite of liability.[181]

Because the psychotherapists in *Tarasoff* appeared to have "actual knowledge" of their patient's propensities,[182] the court's remarks on the standard of care could be seen as dictum.[183] A future court could adopt an actual knowledge standard. One of the problems with such a standard would be the near impossibility in most cases of proving actual knowledge. If the therapist did not make an admission or indulge in equivocal conduct, he would be free to act with almost any degree of negligence. Instead of being more vigilant, a therapist might close his eyes to any threatened conduct for fear of betraying actual knowledge. The effect would be the opposite of what the *Tarasoff* court reasoned social policy required.

Dangerousness, that elusive standard, is the basis for most commitment statutes.[184] Under California's Lanterman-Petris-Short Act,

179. *Id.* at 434-35, 551 P.2d at 342, 131 Cal. Rptr. at 22. *See generally,* PROSSER, THE LAW OF TORTS 145-49, 250-70 (4th ed. 1971).

180. *See, e.g.,* Bullock v. Parkchester Gen. Hosp., 3 App. Div. 2d 254, 160 N.Y.S.2d 117 (1957); Sealey v. Finkelstein, 206 N.Y.S.2d 512 (Sup. Ct. 1960).

181. Bullock v. Parkchester Gen. Hosp., 3 App. Div. 2d 254, 160 N.Y.S.2d 117, 120 (1957). *See also* Homere v. State, 79 Misc. 2d 972, 361 N.Y.S.2d 820 (1974); Taig v. State, 241 N.Y.S.2d 495 (1963).

182. 17 Cal. 3d at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

183. *Id.* at 451, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34 (Mosk, J., concurring and dissenting).

184. *See* Kozol, Boucher & Garofalo, *supra* note 137 at 374. The requirement of

a person can be involuntarily confined for seventy-two hours if a designated professional has reasonable cause to believe he presents a danger to himself or others.[185] Confinement beyond the seventy-two hour period requires even more specific proof of dangerousness. Section 5300 of the Act authorizes confinement for ninety days if the patient has "threatened, attempted, or inflicted physical harm upon . . . another . . . [and] presents . . . an imminent threat of substantial physical harm to others."[186] In practice, this standard has been defined in a very strict and narrow manner.[187] Some people associated with the development of the Act assert that this standard requires a specific overt act witnessed by either a psychiatrist or a police officer.[188]

Arguably, the *Tarasoff* standard should be similar to the commitment standard. The court in *Tarasoff* and commentators have suggested that in many cases a warning should be given in lieu of or in addition to actual confinement.[189] Further, because most of the *Tarasoff* options are less disruptive than actual commitment, a similarity in standards may actually lead to less reliance on commitment as a protective measure.

Although a rough similarity between the standards is desirable, a *Tarasoff* standard of care need not be quite as rigorous as the ninety day commitment standard. First, because it results in a loss of liberty, a commitment procedure requires a higher degree of certainty for due process reasons.[190] In the *Tarasoff* situation, in which a warning may be given in lieu of commitment, such deprivation is not threatened. Second, the societal interest in preventing violence suggests a graduated scale. Once a specific violent act is witnessed, the option of taking any preventative action may no longer be viable. To adopt as the *Tarasoff* standard an exact equivalent to the commitment standard would result in little more protection for potential victims than relying on involuntary commitment alone.

The Medical Malpractice Standard

Rather than adopting the more specific actual knowledge or commitment standard, the *Tarasoff* court indicated that psychotherapists

dangerousness before one can be involuntarily committed now has constitutional dimensions. *See* O'Connor v. Donaldson, 422 U.S. 563 (1975).

185. CAL. WELF. & INST. CODE § 5150 (West Supp. 1977).

186. CAL. WELF. & INST. CODE § 5300 (West 1972). A court hearing and order are required by CAL. WELF. & INST. CODE § 5301 (West 1972).

187. *See* Note, *Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act*, 7 LOY. L.A.L. REV. 93, 113 (1974).

188. *Id.*

189. 17 Cal. 3d 441 n.14, 551 P.2d at 347, 131 Cal. Rptr. at 27; Ayres & Holbrook, *supra* note 5 at 693-94.

190. See notes 155-56 & accompanying text *supra*.

would be judged by the same type of standard as that used for doctors in medical malpractice cases.[191] Such a standard evaluates negligence from the viewpoint of reasonable professional conduct. Because medicine is not an exact science and the doctor must often act swiftly under enormous pressure, there is no liability solely for errors in judgment.[192]

Although the *Tarasoff* court suggested that the analogy between medicine and psychotherapy can be quite close, there are significant differences. The major difference is that the presence of physical illness can usually be objectively ascertained by doctors, but what constitutes mental illness has engaged psychiatrists in seemingly endless argument.[193] The theoretical basis of psychiatric diagnosis, psychiatrists argue, is too complicated, too much in dispute, and too uncertain to be used by a court in fashioning a standard of conduct.[194]

Although this argument still has validity, it may be overstated today. In recent years the courts have examined psychiatric standards in detail and in some cases have adopted detailed requirements for the care and treatment of confined mental patients.[195] One veteran of these cases, Judge Bazelon, of the District of Columbia Circuit, has noted that the disagreements between psychiatrists, "while admittedly of epic proportions, do not seem quantitatively different from those of experts in other fields" with which the courts have dealt in the past.[196]

191. In attempting to forecast whether a patient presents a serious danger, "the therapist need only exercise 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.'" Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25. *See generally* Bardessono v. Michaels, 3 Cal. 3d 780, 788, 478 P.2d 480, 484, 91 Cal. Rptr. 760, 764 (1970); Quintal v. Laurel Grove Hospital, 62 Cal. 2d 154, 159-60, 397 P.2d 161, 164, 41 Cal. Rptr. 577, 580 (1964); 4 WITKIN, SUMMARY OF CALIFORNIA LAW § 514 (8th ed. 1974); D. HARNEY, MEDICAL MALPRACTICE 92 (1973).

192. *See, e.g.*, Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 438, 551 P.2d at 345, 131 Cal. Rptr. at 25; D. HARNEY, MEDICAL MALPRACTICE at 92 (1973); Ayres & Holbrook, *supra* note 5 at 688.

193. *See generally* Mechanic, *supra* note 51 at 122; Ennis & Litwack, *supra* note 137 at 699-708.

194. *See, e.g.*, Note, *Medical Malpractice, The Liability of Psychiatrists*, 48 NOTRE DAME LAW. 693, 696-702 (1973).

195. *See, e.g.*, Wyatt v. Alderholt, 503 F.2d 1305 (5th Cir. 1974); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974); Wyatt v. Stickney, 344 F. Supp. 373 and 344 F. Supp. 387 (M.D. Ala. 1972) *enforcing* 325 F. Supp. 781, *aff'd in part, remanded in part* (M.D. Ala. 1972). *See generally* COMMITTEE ON THE OFFICE OF ATTORNEY GENERAL, NATIONAL ASSOCIATION OF ATTORNEY GENERALS, THE RIGHT TO TREATMENT IN MENTAL HEALTH LAW (1976); TANCREDI, LIEB & SLABY, LEGAL ISSUES IN PSYCHIATRIC CARE 40 (1975).

196. Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 744 (1969).

Even some of the commentators who argue that psychiatric standards are elusive accept the fact that social requirements necessitate court intervention.[197]

Commentators have suggested that a national psychiatric malpractice standard may be imminent, facilitated by the use of canons of ethics and the emergence of professional standards review organizations among the various disciplines.[198] A mechanical adoption of the medical model would not be appropriate for psychotherapy. A standard of care for the *Tarasoff* duty must take realistic notice of the uncertainties that accompany psychiatric diagnosis and prediction. As one court explained, "the concept of 'due care' in appraising psychiatric problems . . . must take account of the difficulty often inevitable in definitive diagnosis."[199] Thus a standard analogous to the medical standard can be helpful in defining the appropriate standard of care in the *Tarasoff* situation. Stated without qualification or clarification, such a standard would be too vague to give much indication to the practicing psychotherapist of what his duty required.

A Proposed Standard of Foreseeability: Clear Danger

A practical standard of foreseeability must acknowledge the difficulties of prediction, the importance of confidentiality, general professional standards, and the commitment standard. These constraints suggest a standard requiring a psychotherapist to act only if there is a clear danger of serious harm to a third person. A clear danger should be conclusively presumed whenever a therapist has shown by conduct or admission an actual awareness of the danger. In accord with the *Tarasoff* court's requirements, this standard would not require routine revelations, would not penalize the psychotherapist for honest errors of judgment, and would not be tied to professional standards of conduct. Although there is considerable disagreement among psychotherapists concerning the prediction of violence, the combination of a patient history of aggressive or violent conduct and a specific threat of violence presents a clear danger of violence few psychotherapists would ignore.[200] Faced with such a situation, the psychotherapist possessing a reasonable degree of skill, knowledge, and care would take reasonable precautions to protect the intended victim. The application of the standard in other situations would depend on the facts of each case.

197. *See, e.g.*, Mechanic, *supra* note 51 at 122.

198. *See, e.g.*, TANCREDI, LIEB & SLABY, LEGAL ISSUES IN PSYCHIATRIC CARE 120 (1975); D. DAWIDOFF, THE MALPRACTICE OF PSYCHIATRISTS 62-65 (1973).

199. Hicks v. United States, 511 F.2d 407, 417 (D.C. Cir. 1975).

200. See notes 151-53 & accompanying text *supra*.

The standard fits into the general scheme of psychiatric alternatives. It does not require as high a proximity of danger as the ninety day commitment, "imminent danger" standard.[201] If there is a clear danger, the psychotherapist may have the option of initiating short term commitment procedures. Unless the danger is also imminent, he cannot cause the patient to be held beyond fourteen days.[202] The clear danger standard thus offers an inherent safeguard against casually imposed long term commitment. At the same time, the standard offers greater protection from serious violence by requiring reasonable conduct to protect the threatened person before the level of danger required by the long term commitment standard is reached.

This proposed standard requires psychotherapists to act only when there is a clear danger of serious harm to a third person. The public is afforded greater protection from violence without sacrificing the effectiveness of psychotherapy or the privacy of the patient. Under such a standard, the *Tarasoff* duty ceases to be an ambiguous, speculative threat to the practicing psychotherapist.

Conclusion

Tarasoff need not put an insuperable burden on the psychotherapist. The opinion is a recognition of an ethical duty and a social necessity. Its impact, despite the storms of protest, will be limited. The competent therapist need not make any significant changes in his methods. The case marks both a milestone in California's modern creation of legal duties and another recognition that power has its responsibilities. Psychotherapists, the object of an unrealistic deference by courts in the past, are now called upon to meet the public responsibilities they have fostered. Ultimately, *Tarasoff* may augur the maturity of the profession.

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201. See note 169 & accompanying text *supra*.
202. *Id.*

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